PRINTED: 01/26/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS5423AGC 01/22/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8280 HICKAM AVE **EXCELLENT ADULT CARE SERVICES, INC** LAS VEGAS, NV 89129 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 **Initial Comments** Y 000 Surveyor: 28276 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted at your facility on 1/22/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility was licensed for 10 Residential Facility for Group beds for elderly and disabled persons, and/or persons with chronic illnesses, and/or persons with mental illnesses Category II residents. The census at the time of the survey was two. Two resident files were reviewed and four employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of D. The following deficiencies were identified: Y 103 Y 103 449.200(1)(d) Personnel File - NAC 441A / SS=F **Tuberculosis**

1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.

NAC 449.200

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Based on record review on 1/22/10, the facility failed to ensure 2 of 4 Employees had current, at

background checks completed (Employee #3 and

least once every 5 years, criminal history

#4).

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
				A. BUILDING B. WING					
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NAME OF PF	ROVIDER OR SUPPLIER			RESS, CITY, STA	ATE, ZIP CODE				
EXCELLENT ADULT CARE SERVICES, INC		ICES, INC	8280 HICKAM AVE LAS VEGAS, NV 89129						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUI REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE		
Y 105	Continued From page	Continued From page 2		Y 105					
	Findings include:								
	The file for Employee #3 failed to contain evidence of fingerprints, or an FBI background check.								
	The file for Employee evidence of an FBI ba								
	Severity: 2 Scope	e: 2							
Y 274 SS=C	449.2175(5) Service	of Food - Substitutions		Y 274					
	be documented and least 90 days after	or an item on the menu kept on file with the mer the substitution occurs posted in a conspicuous rice of the meal.	nu for . A						
	Surveyor: 28276 Based on observation the facility failed to do	ot met as evidenced by: n and interview on 1/22/ ocument substitutions o iled to follow the menu	/10, n the						
	Severity: 1 Scope:	3							
Y 530 SS=C	449.260(1)(e) Activiti	es for Residents		Y 530					
	NAC 449.260 (e) Provide for the res	sidents at least 10 hour	S						

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the equipment in accordance with the orders of a

(1) The resident's physician evaluates periodically the condition of the resident which

necessitates his use of oxygen;

physician. (b) Ensure That:

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS5423AGC 01/22/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8280 HICKAM AVE **EXCELLENT ADULT CARE SERVICES, INC** LAS VEGAS, NV 89129 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 693 Continued From page 4 Y 693 (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. This Regulation is not met as evidenced by: Surveyor: 28276 Based on observation on 1/22/10, the facility failed to ensure oxygen tanks were secured in a rack or to the wall in 1 of 1 resident rooms that utilized oxygen (Resident #2's bedroom). One unsecured oxygen tank was observed in a cabinet in the garage. Severity: 2 Scope: 3

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subsection, a caregiver shall assist in the administration of medication to a resident if the resident needs the caregiver's assistance. A caregiver may assist the ultimate user of controlled substances or dangerous drugs only if the conditions prescribed in subsection 6 of NRS

449.037 are met.

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received medications as prescribed (Resident

Resident #2 was prescribed Finasteride,

propecia, 5 milligrams one tablet every day. The

#2).

Findings include:

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by:

Eighteen medications were observed in the medication cabinet belonging to Resident #4. Interview with Employee #4 revealed Resident #4

Based on observation and interview on 1/22/10, the facility failed to destroy medications after after a resident had been transferred (Resident #4).

Surveyor: 28276

Findings include:

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This Regulation is not met as evidenced by: Surveyor: 28276
Based on observation on 1/22/10, the facility failed to keep medications for 2 of 2 residents in a locked area (Resident #1 and #2). The medications for Resident #1 and #2 were kept in a cabinet in the kitchen. The cabinet was equipped with a lock but was not locked.

locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has

been provided a key.

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING _ NVS5423AGC 01/22/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EXCELLENT ADULT CARE SERVICES, INC		8280 HICKAM AVE LAS VEGAS, NV 89129				
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Y 920	Continued From page 9		Y 920			
	Severity: 2 Scope: 3					
Y 930 SS=C	Y 930 449.2749(1)(a) Resident File-Storage, Res Information		Y 930			
	NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related the resident, including without limitation: (a) The full name, address, date of birth and social security number of the resident.					
	This Regulation is not met as evidenced by: Surveyor: 28276 Based on observation on 1/22/10, the facility failed to keep 2 of 2 resident files (Resident and #2) in a locked place. The files were observed in a cabinet off the kitchen. The cabinet was equipped with a lock, but was no locked.	, #1				
	Severity: 1 Scope: 3					
Y1001 SS=D	449.2758(1) Training Req-Elderly Disabled		Y1001			
	NAC 449.2758 1. Within 60 days after being employed by a residential facility for elderly or disabled personal statement of the second statement of t					

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employed at the facility, attend not less than 8 hours of training concerning care for residents who are suffering from mental illnesses.

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of 4 employees (Employee #4).

Scope: 1

Severity: 2

Bureau of Health Care Quality and Compliance								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDE IDENTIFIC		(X1) PROVIDER/SUPPLIER/ORDER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/ORDER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/ORDER/SUPPLIER/SUPPLIER/ORDER/SUPPLIER/SUPP	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/22/2010	
NAME OF D		11100420AGC	STREET ADD	DESS CITY STA	ATE ZIR CODE		22/2010	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
EXCELLENT ADULT CARE SERVICES, INC			8280 HICKAM AVE LAS VEGAS, NV 89129					
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